

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>				c. LENGTH OF STAY IN lb <u>1mo. 23days</u> X <u>Federalsburg, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Houston Branch Road</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Lennon Absher</u>				4. DATE OF DEATH Month Day Year <u>Jan. 4 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1957</u>	
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>23</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>23</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Mack K. Absher</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Virginia Jester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Mrs. Joyce Absher</u>		Address <u>Federalsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalitis</u> 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature Closure Fontanel</u> DUE TO (c) <u>Respiratory Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1mo</u> <u>1mo</u> <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson O. George</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dawson O. George</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md. R.F.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tanner D. Williams</u>				ADDRESS <u>Federalsburg, Md.</u>		24. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 7 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00452

455

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>BREEDING</u> Last <u>BREEDING</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Mildred B. Butler Denton, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>502.1 Myocarditis Chronica</u> DUE TO (b) <u>Pneumonia Chronica</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>34 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 1950</u> , to <u>Jan 30, 1958</u> , that I last saw the deceased alive on <u>Mar Jan 30, 1958</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dawson D. George</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md</u>			
PHYSICIAN'S NAME (Type) <u>DAWSON D. GEORGE</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Henson</u> ADDRESS <u>Denton, Ind</u>				24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

BUREAU V. S.

FEB 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00453

456

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>life</u>				d. STREET ADDRESS <u>Rural Denton</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BARBARA</u> Last <u>BRUBAKER</u>				4. DATE OF DEATH Month <u>DAN</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 16, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Brubaker</u>				14. MOTHER'S MAIDEN NAME <u>Lunkobol Bolick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs Mildred Barford Denton, wid.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u> <u>444 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension noted seven years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>28</u> , to <u>Jan 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>58</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Paul Knotts</u>		M.D. <u>  </u>		ADDRESS (Street, city or town, state) <u>406 Market St</u>		DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>		Denton, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Monahan</u>				ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15 1900*  
5. Place of birth: *John Doe*  
6. Usual residence: *John Doe*  
7. Cause of death: *Heart Disease*  
8. Date of death: *Jan 20 1958*  
9. Time of death: *10:00 AM*  
10. Place of death: *John Doe*  
11. Signature of physician: *John Doe*  
12. Signature of registrar: *John Doe*

13. Name of informant: *John Doe*  
14. Address of informant: *John Doe*  
15. Date of report: *Jan 20 1958*  
16. Signature of informant: *John Doe*  
17. Name of physician: *John Doe*  
18. Address of physician: *John Doe*  
19. Date of report: *Jan 20 1958*  
20. Signature of physician: *John Doe*  
21. Name of registrar: *John Doe*  
22. Address of registrar: *John Doe*  
23. Date of report: *Jan 20 1958*  
24. Signature of registrar: *John Doe*

BUREAU V. S.

JAN 27 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

457

## CERTIFICATE OF DEATH

00454

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		c. LENGTH OF STAY IN 1b <u>30 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida</u> <u>Isabelle</u> <u>Cain</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>24</u> <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Sparks</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rome Cain</u>		Address <u>Ridgely, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 10</u> , 19 <u>57</u> , to <u>Jan. 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 24</u> , 19 <u>58</u> , and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>1/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>		22d. LOCATION (City, town, or county) (State) <u>Harrington, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulsis</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00455

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Caroline</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural Denton</span> c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">8 Yrs.</span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">None</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Caroline</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural Denton</span> d. STREET ADDRESS <span style="font-size: 1.2em;">None</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">Edward</span> Middle <span style="font-size: 1.2em;">Carroll</span> Last <span style="font-size: 1.2em;">Carroll</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">1</span> Day <span style="font-size: 1.2em;">28</span> Year <span style="font-size: 1.2em;">19 58</span>									
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">4/6/1885</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">72</span> yrs.		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;">72</span> Days <span style="font-size: 1.2em;">28</span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;">28</span> Min. <span style="font-size: 1.2em;">19</span>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Farm Owner</span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>				<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Carroll</span>						<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary Spencer</span>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">2-17-30-9507</span>				<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Lovie Carroll Denton, Maryland</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Shock. Hemorrhage</span></p> <p><b>DUE TO</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="font-size: 1.2em;">Gun Shot Wound in Chest</span></p> <p><b>DUE TO</b></p> <p><b>(b)</b> <span style="font-size: 1.2em;">Gun Shot Wound in Chest</span></p> <p><b>(c)</b> <span style="font-size: 1.2em;">Sudden</span></p> </div> <div style="width: 35%;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><span style="font-size: 1.2em;">Few Minutes</span></p> </div> </div> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b></p>													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="font-size: 1.2em;">5</span> o. m. <span style="font-size: 1.2em;">11/28</span> p. m. <span style="font-size: 1.2em;">19 58</span>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Home</span>		<b>20f. (City or town)</b> <span style="font-size: 1.2em;">Rural Denton</span>		<b>(County)</b> <span style="font-size: 1.2em;">Caroline</span>		<b>(State)</b> <span style="font-size: 1.2em;">Md</span>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">Dawson O. George</span>						<b>DATE SIGNED</b> <span style="font-size: 1.2em;">1/29/58</span>							
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Dawson O. George</span>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>				<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">2/1/58</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Concord</span>				<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.2em;">Near Denton, Maryland</span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">J. E. Boulaie Greensboro, Md.</span>						<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">JAN 31 1958</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
FAMILY HISTORY		SOCIAL HISTORY		PATHOLOGICAL DATA		LABORATORY DATA		POST-MORTEM DATA	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		OFFICE	

BUREAU X. 8

JAN 31 1958

RECEIVED

## CERTIFICATE OF DEATH

00456

Reg. Dist. No.

459

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>		c. LENGTH OF STAY IN 1b <b>4 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cherry Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Viola</b> Last <b>Cherry</b>		4. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/8/1870</b>
9. AGE (In years last birthday) yrs. <b>87</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Downes</b>		14. MOTHER'S MAIDEN NAME <b>No Record Annie Cooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Orville Cherry Greensboro, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1</b> , 19 <b>57</b> , to <b>Jan. 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 14</b> , 19 <b>58</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>1-15-58</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/18/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro,</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>JOHN J. BROWN</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>1890</b></p>		<p>4. Place of birth: <b>NEW YORK</b></p>	
<p>5. Date of death: <b>1958</b></p>		<p>6. Place of death: <b>BALTIMORE</b></p>	
<p>7. Cause of death: <b>Heart Disease</b></p>		<p>8. Manner of death: <b>Natural</b></p>	
<p>9. Signature of physician: <b>[Signature]</b></p>		<p>10. Signature of registrar: <b>[Signature]</b></p>	
<p>11. Date of registration: <b>1958</b></p>		<p>12. Place of registration: <b>BALTIMORE</b></p>	
<p>13. Name of informant: <b>[Name]</b></p>		<p>14. Address of informant: <b>[Address]</b></p>	
<p>15. Name of informant: <b>[Name]</b></p>		<p>16. Address of informant: <b>[Address]</b></p>	
<p>17. Name of informant: <b>[Name]</b></p>		<p>18. Address of informant: <b>[Address]</b></p>	
<p>19. Name of informant: <b>[Name]</b></p>		<p>20. Address of informant: <b>[Address]</b></p>	
<p>21. Name of informant: <b>[Name]</b></p>		<p>22. Address of informant: <b>[Address]</b></p>	
<p>23. Name of informant: <b>[Name]</b></p>		<p>24. Address of informant: <b>[Address]</b></p>	
<p>25. Name of informant: <b>[Name]</b></p>		<p>26. Address of informant: <b>[Address]</b></p>	
<p>27. Name of informant: <b>[Name]</b></p>		<p>28. Address of informant: <b>[Address]</b></p>	
<p>29. Name of informant: <b>[Name]</b></p>		<p>30. Address of informant: <b>[Address]</b></p>	
<p>31. Name of informant: <b>[Name]</b></p>		<p>32. Address of informant: <b>[Address]</b></p>	
<p>33. Name of informant: <b>[Name]</b></p>		<p>34. Address of informant: <b>[Address]</b></p>	
<p>35. Name of informant: <b>[Name]</b></p>		<p>36. Address of informant: <b>[Address]</b></p>	
<p>37. Name of informant: <b>[Name]</b></p>		<p>38. Address of informant: <b>[Address]</b></p>	
<p>39. Name of informant: <b>[Name]</b></p>		<p>40. Address of informant: <b>[Address]</b></p>	
<p>41. Name of informant: <b>[Name]</b></p>		<p>42. Address of informant: <b>[Address]</b></p>	
<p>43. Name of informant: <b>[Name]</b></p>		<p>44. Address of informant: <b>[Address]</b></p>	
<p>45. Name of informant: <b>[Name]</b></p>		<p>46. Address of informant: <b>[Address]</b></p>	
<p>47. Name of informant: <b>[Name]</b></p>		<p>48. Address of informant: <b>[Address]</b></p>	
<p>49. Name of informant: <b>[Name]</b></p>		<p>50. Address of informant: <b>[Address]</b></p>	
<p>51. Name of informant: <b>[Name]</b></p>		<p>52. Address of informant: <b>[Address]</b></p>	
<p>53. Name of informant: <b>[Name]</b></p>		<p>54. Address of informant: <b>[Address]</b></p>	
<p>55. Name of informant: <b>[Name]</b></p>		<p>56. Address of informant: <b>[Address]</b></p>	
<p>57. Name of informant: <b>[Name]</b></p>		<p>58. Address of informant: <b>[Address]</b></p>	
<p>59. Name of informant: <b>[Name]</b></p>		<p>60. Address of informant: <b>[Address]</b></p>	
<p>61. Name of informant: <b>[Name]</b></p>		<p>62. Address of informant: <b>[Address]</b></p>	
<p>63. Name of informant: <b>[Name]</b></p>		<p>64. Address of informant: <b>[Address]</b></p>	
<p>65. Name of informant: <b>[Name]</b></p>		<p>66. Address of informant: <b>[Address]</b></p>	
<p>67. Name of informant: <b>[Name]</b></p>		<p>68. Address of informant: <b>[Address]</b></p>	
<p>69. Name of informant: <b>[Name]</b></p>		<p>70. Address of informant: <b>[Address]</b></p>	
<p>71. Name of informant: <b>[Name]</b></p>		<p>72. Address of informant: <b>[Address]</b></p>	
<p>73. Name of informant: <b>[Name]</b></p>		<p>74. Address of informant: <b>[Address]</b></p>	
<p>75. Name of informant: <b>[Name]</b></p>		<p>76. Address of informant: <b>[Address]</b></p>	
<p>77. Name of informant: <b>[Name]</b></p>		<p>78. Address of informant: <b>[Address]</b></p>	
<p>79. Name of informant: <b>[Name]</b></p>		<p>80. Address of informant: <b>[Address]</b></p>	
<p>81. Name of informant: <b>[Name]</b></p>		<p>82. Address of informant: <b>[Address]</b></p>	
<p>83. Name of informant: <b>[Name]</b></p>		<p>84. Address of informant: <b>[Address]</b></p>	
<p>85. Name of informant: <b>[Name]</b></p>		<p>86. Address of informant: <b>[Address]</b></p>	
<p>87. Name of informant: <b>[Name]</b></p>		<p>88. Address of informant: <b>[Address]</b></p>	
<p>89. Name of informant: <b>[Name]</b></p>		<p>90. Address of informant: <b>[Address]</b></p>	
<p>91. Name of informant: <b>[Name]</b></p>		<p>92. Address of informant: <b>[Address]</b></p>	
<p>93. Name of informant: <b>[Name]</b></p>		<p>94. Address of informant: <b>[Address]</b></p>	
<p>95. Name of informant: <b>[Name]</b></p>		<p>96. Address of informant: <b>[Address]</b></p>	
<p>97. Name of informant: <b>[Name]</b></p>		<p>98. Address of informant: <b>[Address]</b></p>	
<p>99. Name of informant: <b>[Name]</b></p>		<p>100. Address of informant: <b>[Address]</b></p>	

BUREAU V. 1

JAN 20 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00457

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>EARLE</u> Last <u>HARRIS</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1928</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F.W. Harris</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Lee Wooster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. A. Earle Harris Denton Ltd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Spine</u> DUE TO <u>Crushed Chest -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Truck body fell on him</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1-13 1958</u> Hour <u>4:45</u> p.m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Earle Service Station</u>	20f. (City or town) <u>Rural Denton</u> (County) <u>Caroline</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAWSON O. GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 16, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virginia Mcnessow Denton, Ltd.</u>		24a. REC'D BY REGISTRAR <u>JAN 17 1958</u>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 17 1958  
BUREAU V. 3



00458

461

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Williston</b>		e. STREET ADDRESS <b>Near Williston</b>	
3. NAME OF DECEASED (Type or print) First <b>Haywood</b> Middle <b>Haynes</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Phillips Packing Co. Caroline Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles C. Haynes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Beulah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Carrie L. Haynes, Denton, Maryland, R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause or time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 5, 1958</b> to <b>Jan. 17, 1958</b> , that I last saw the deceased alive on <b>Jan. 14, 1958</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. L. Small</b>		DATE SIGNED <b>1-18-58</b>	
PHYSICIAN'S NAME (Type) <b>H. L. Small, M.D.</b>		M.D. <b>Denton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Prampton and Son, Federalsburg, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>JAN 23 '58</b>	
24. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JAN 23 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00459

462

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Tanyard</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Manie</u> Middle <u>May</u> Last <u>Hubbard</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <del>Married</del> <input checked="" type="checkbox"/> <del>Never married</del> <input checked="" type="checkbox"/> <del>Widowed</del> <input checked="" type="checkbox"/> <del>Divorced</del> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>00</u> Min. <u>00</u>	IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Harding</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Christopher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>H. Ormond Hubbard, Preston, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stokes Adrenal Syndrome</u> DUE TO <u>Complete heart block.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete heart Hypertensive arteriosclerotic heart disease - 15 yrs.</u> DUE TO (c) <u>Complete heart Hypertensive arteriosclerotic heart disease - 15 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>76 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>00</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20</u> , 19 <u>44</u> , to <u>1-31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>58</u> , and that death occurred at <u>6:30 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold B. Plummer</u> M.D. <u>Preston Md</u>				DATE SIGNED <u>2-1-58</u>			
PHYSICIAN'S NAME (Type) <u>Harold B. Plummer, M.D.</u>				<u>Preston, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 3, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Framptom and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Ch. Leach</u>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS DEATHS	
SIGNED BY		WITNESSED BY	
DATE		PLACE	

BUREAU V. S.

FEB 3 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

463

## CERTIFICATE OF DEATH

Reg. Dist. No.

00460

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
c. LENGTH OF STAY IN lb <b>50 Yrs.</b>		d. STREET ADDRESS <b>Sunset Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>T.</b> Last <b>Lister</b>		4. DATE OF DEATH Month <b>1</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/1876</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Trice</b>		14. MOTHER'S MAIDEN NAME <b>Emily Jester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Edna Gray Greensboro, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Dis.</b> DUE TO (c) <b>Residual Hemiplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>↓</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 19 56</b> to <b>Jan. 4, 19 58</b> , that I last saw the deceased alive on <b>Jan. 4, 19 58</b> , and that death occurred at <b>505A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b> DATE SIGNED <b>1/6/58</b>			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		DATE SIGNED <b>1/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaier</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 8 '58</b>	
ADDRESS <b>Greensboro, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Outback</b>	

BUREAU V. S.

1958 8 JAN

RECEIVED



464

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	c. LENGTH OF STAY IN 1b <b>60 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		d. STREET ADDRESS <b>None</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Linwood</b> Middle <b>Riddleberger</b> Last <b>Riddleberger</b>		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Riddleberger</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Belle Miley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward Riddleberger</b> Address <b>Greensboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 2, 1957</b> , to <b>Jan. 14, 1958</b> , that I last saw the deceased alive on <b>Jan. 13, 1958</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>1-15-58</b>			
ACTUAL SIGNATURE <b>Charles H. Stoneside</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles H. Stoneside, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulees</b> ADDRESS <b>Greensboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1953

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

465

## CERTIFICATE OF DEATH

00462  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>May</u> Last <u>Sparks</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 7 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Dean</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edward Sparks, Ridgely, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular heart failure</u> <u>443X</u> DUE TO <u>Hypertensive cardiac disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Heart Disease</u> DUE TO (c) <u>Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>1 year.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 187</u> , to <u>Jan 5, 1958</u> , that I last saw the deceased alive on <u>Jan 5, 1958</u> , and that death occurred at <u>5:47 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Winnaco</u> M.D.		ADDRESS (Street, city or town, state) <u>Ridgely, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNACOTT</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 7 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Denton, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Denton</u>	

JAN 17 1958

RECEIVED

466

## CERTIFICATE OF DEATH

Reg. Dist. No.

00463

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marydel</b>		c. LENGTH OF STAY IN 1b <b>3 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rufus</b> <b>Benson</b> <b>Stevens</b>		4. DATE OF DEATH <b>1</b> <b>22</b> <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/ ? /1957</b>
9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR <b>3</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Leon Demby</b>		14. MOTHER'S MAIDEN NAME <b>Grace Stevens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leon Demby Marydel, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> <b>752x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Born with it</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>(u)</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 16, 1958</b> to <b>Jan 22, 1958</b> that I last saw the deceased alive on <b>Jan 16, 1958</b> and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Dufetecoff</b>		DATE SIGNED <b>Feb 1/23/58</b>	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blanco</b>		22d. LOCATION (City, town, or county) (State) <b>Hartly, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulois Greensboro, Md.</b>		24a. RECEIVED BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION		EDUCATION		RELIGION		BIRTH DATE		BIRTH PLACE		BIRTH CERT. NO.		BIRTH DATE		BIRTH PLACE		BIRTH CERT. NO.	
JAMES H. HARRIS		35		M		W		MARRIED		LABORER		8		METHODIST		JAN 15 1923		BALTIMORE, MD		12345		JAN 15 1923		BALTIMORE, MD		12345	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS		PREVIOUS INJURIES		PREVIOUS DISEASES		PREVIOUS SYMPTOMS		PREVIOUS SIGNS	
JAN 24 1958		HOME		HEART DISEASE		NATURAL		2 WEEKS		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF COURT		SIGNATURE OF JURY		SIGNATURE OF COURT		SIGNATURE OF JURY	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
JAN 24 1958  
BUREAU V. B.



## Reg. Dist. No.

467

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution--Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HENRY THOMAS</u>		4. DATE OF DEATH <u>JAN 23 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 1, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR <u>89</u> Months <u>23</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>ZINNIE [unknown]</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH, <u>34 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>12</u> Day <u>22</u> Year <u>1958</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Denton, Md.</u>	20f. (City or town) <u>Denton</u> (County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Dec 11 1955</u> to <u>Jan 22 1958</u> , that I last saw the deceased alive on <u>Jan 22 1958</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. L. Small</u>		DATE SIGNED <u>JAN 28 1958</u>	
PHYSICIAN'S NAME (Type) <u>H. L. SMALL M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Jan 27, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) <u>Near Denton Md</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ward Womerton</u>		24. REC'D BY REGISTRAR <u>W. Womerton</u>	
ADDRESS <u>Denton</u>		DATE <u>JAN 28 1958</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1893		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
JAN 28 1958		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
JAN 28 1958		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NO	

BUREAU V. 1

JAN 28 1958

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00465

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		c. LENGTH OF STAY IN 1b <b>10yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Truxon</b> Last <b>Truxon</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 15 1923</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>any kind</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wesley Truxon</b>		14. MOTHER'S MAIDEN NAME <b>Etha Steward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW2</b>	
17. INFORMANT <b>Isaac Rynes, Hillsboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>490X</b> DUE TO (c) <b>490X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dawson O. George</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DAWSON O. GEORGE</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 7 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sandtown</b>		22d. LOCATION (City, town, or county) (State) <b>Hillsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Moore</b>		24a. REC'D BY REGISTRAR <b>Jan 9 '58</b>	
ADDRESS <b>Hillsboro, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Reuben</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

469

## CERTIFICATE OF DEATH

00466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hyson</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Hyson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Turner</u>				d. STREET ADDRESS <u>Turner</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>North George Wrightson Turner</u> First Middle Last				4. DATE OF DEATH Month <u>Jan</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 12, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noah Turner</u>				14. MOTHER'S MAIDEN NAME <u>Kathleen Tatum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>not</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs N. Geo. W. Turner, Federal Hwy, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>57</u> , to <u>Jan. 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 12</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>1-13-58</u>							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				DATE SIGNED <u>1-13-58</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Newerton</u>				ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 17 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		JAN 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		JAN 4 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	

BUREAU V. S.

JAN 17 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00467

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>King</u> Last <u>Willeij</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph King Bramble</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Smart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or kind of service)		16. SOCIAL SECURITY NO. <u>Mr. Salmagie Gartin, Federalburg</u>	
17. INFORMANT <u>Mr. Salmagie Gartin, Federalburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (left)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1957</u> to <u>1/27</u> , 19 <u>58</u> or I last saw the deceased alive on <u>1/27</u> , 19 <u>58</u> , and that death occurred at <u>1.20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Anderson</u> M.D.		DATE SIGNED <u>Federalburg, Md. 1/30/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack S. Mullooly, E. N. Market</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1890		BALTIMORE		BALTIMORE		U.S.A.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1915		BALTIMORE		BALTIMORE		U.S.A.		1938		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		COUNTRY OF BURIAL	
1938		BALTIMORE		BALTIMORE		U.S.A.		1938		BALTIMORE		BALTIMORE		U.S.A.	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		SIGNATURE OF CORONER		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		1938		BALTIMORE		BALTIMORE		U.S.A.		J. H. HARRIS		1938		BALTIMORE	
SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE	
J. H. HARRIS		1938		BALTIMORE		BALTIMORE		U.S.A.		J. H. HARRIS		1938		BALTIMORE	

BUREAU V. 3

FEB 3 1938

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

471

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Federalsburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Denton Road</b>			d. STREET ADDRESS <b>1 Park Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Walter</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1930</b>		9. AGE (In years last birthday) <b>27</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Caroline Poultry</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Williams</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Williams</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>267-38-9995</b>	17. INFORMANT <b>Dorothy J. Williams, Federalsburg, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock - Hemorrhage</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gun shot wound in chest</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>10:30</b> a.m. <b>1-4</b> 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Federalsburg</b>		20f. (City or town) (County) (State) <b>Caroline Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Dawson O. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-5-57</b>	
EXAMINER'S NAME (Type) <b>Dawson O. George, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 13, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>			24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - JANNONIE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 13 1938

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